IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 9023

August 10, 2006

Samuel R. Long, Administrator
Idaho Falls Health & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404

Provider #: 135107

Dear Mr. Long:

On July 25, 2006, a fire safety survey was conducted at Idaho Falls Health & Rehabilitation by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be widespread deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 23, 2006**. Failure to submit an acceptable PoC by **August 23, 2006**, may result in the imposition of civil monetary penalties by **September 12, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 29, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 29, 2006**. A change in the seriousness of the deficiencies on **August 29, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 29, 2006** includes the following:

Denial of payment for new admissions effective **October 25, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 25, 2007**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW

3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 25, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 23, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 23, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction

MPG/dmj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135107	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/25/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS HEALTH & REHABILITATION	3111 CHANNING WAY IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	INITIAL COMMENTS Type of structure: The facility is a single story, type V (111) construction with a composite pitched roof and multiple exits to grade with four residential wings, a service wing, and a central core. The facility was originally constructed/completed on November 30,1988 . It is fully sprinklered with fire alarm and detection devices. Currently the facility is licensed for 108 beds and had a census of 97. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on July 25, 2006. The facility was surveyed under the Life Safety Code 2000 Edition, Existing Health Care Occupancy adopted March 11, 2003. In accordance with CFR 42, 483.70. The surveyors conducting the survey were: Debra Ransom, RN, RHIT Bureau Chief Facility Standards Mark Grimes, Supervisor Facility Fire Safety & Construction Taylor Barkley Health Facility Surveyor	K 000	RECEIVED AUG 22 2006 FACILITY STANDARDS	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

HCA 8-21-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these

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K 018	Continued From Page 1 closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This Standard is not met as evidenced by: Based on observation and testing of smoke enclosure doors during a tour of the building on 7/25/06, the facility failed to ensure compliance by not maintaining corridor smoke compartment doors that would latch and resist the passage of smoke. 2 of 5 smoke compartment doors would not close and latch completely affecting 26 of 97 residents, in the event of a fire. At the time of the survey the licensed bed capacity was 108 and the census was 97. Findings included: 1) During a tour of the facility on 7/25/06 at 9:14 a.m. it was observed by the survey team and witnessed by the Maintenance Director that the corridor smoke separation door on wing 300 would not close and latch completely. 2) During a tour of the facility on 7/25/06 at 9:40 a.m. it was observed by the survey team and witnessed by the Maintenance Director that the corridor smoke separation door on wing 200 would not close and latch completely.	K 018	"The filing of this POC is made pursuant to both state and federal requirements and does not constitute an admission to the allegations cited herein." K 018 INDENTIFIED RESIDENT ACTION: No residents were specifically identified, but this issue has the potential to affect all residents. CORRECTIVE ACTION: The facility adjusted fire doors on corridor 200 & 300 to ensure the doors operate properly. ONGOING COMPLIANCE: The facility Maintenance Department will include the fire doors on their facility audit tools. QUALITY ASSURANCE: The Maintenance Director will monitor for compliance. Areas of concern will be addressed as needed. Completion date: 8-29-06	

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K 018	Continued From Page 2	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This Standard is not met as evidenced by: Based upon observation and staff interview, the facility failed to ensure smoke barrier walls were not penetrated. This deficient practice affected staff and approximately 40 residents in wings 100 and 200 and also impacting the center core of the facility including the nurses ' station and TV room. At the time of the survey the facility was licensed for 108 beds and had a census of 97. Findings include: During the facility tour on 7/25/06 at 10:12 a.m. it was observed that the smoke barrier above the separation door on wing 100 had been penetrated by drilling holes for conduit and IT cabling and was left unsealed. These opening would allow the passage of smoke between the smoke compartment and the center core of the facility. Additional penetrations of a similar nature were observed in the smoke barriers between wing 200 and the center core, as well as the service corridor and center core. This was	K 025	K 025 INDENTIFIED RESIDENT ACTION: No residents were specifically identified, but this issue has the potential to affect all residents. CORRECTIVE ACTION: The smoke barrier on 100 & 200 were caulked in areas affected by the IT cable penetration. ONGOING COMPLIANCE: The facility will ensure contractors of future projects maintain smoke barriers and maintenance department will audit completed work to ensure compliance. QUALITY ASSURANCE: The Maintenance Director will monitor for compliance. Areas of concern will be addressed as needed. Completion date: 8-29-06	

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K 025	Continued From Page 3 acknowledged by the Maintenance Director and confirmed that it had occurred during a recent IT upgrade.	K 025		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based upon observation and staff interview, the facility failed to ensure that hazardous area smoke resistance was maintained in this fully sprinklered facility. This deficient practice affected two of five wings including a dining room and a wing occupied by 19 patients. At the time of the survey the facility was licensed for 108 beds and census was 97. Findings include: 1) During the facility tour on 7/25/06 at approximately 10:45 a.m. a sprinkler head escutcheon plate in the laundry room was observed to be loose, revealing a 1 inch gap which would allow smoke to penetrate from the hazardous area and enter the service hall smoke compartment including the dining room.	K 029	K 029 INDENTIFIED RESIDENT ACTION: No residents were specifically identified, but this issue has the potential to affect all residents. CORRECTIVE ACTION: 1-The facility adjusted the sprinkler head escutcheon plate in the laundry room to remove the gap to prevent smoke penetration. 2- The attic hatch in the service electrical room was closed. 3- The opening in the mechanical room in the 100 wing was caulked and sealed with smoke barrier caulk to prevent compromising the integrity of the smoke compartment ONGOING COMPLIANCE: The facility Maintenance Department will continue to monitor any areas of concern. QUALITY ASSURANCE: The Maintenance Director will monitor for compliance. Areas of concern will be addressed as needed. Completion date: 8-29-2006	

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K 029	Continued From Page 4 2) During the facility tour on 7/25/06 at approximately 11:00 a.m. an attic hatch in the service hall electrical room was observed to be left open and a ladder extended into the hatch area. This opening; approximately 20 inches by 30 inches, was closed by the Maintenance Director immediately. The opening in the hazardous area effected the staff and residents in the service wing including the dining room. 3) During the facility tour on 7/25/06 at 11:10 a.m. an opening approximately 2 inches by 36 inches was observed in the mechanical room of the 100 wing. This opening was an unsealed penetration of the hazardous area where conduit extended from electrical and phone panels into the attic space compromising the integrity of the smoke compartment.	K 029		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Based upon observation the facility failed to ensure complete coverage of the sprinkler system throughout the facility, affecting the staff and residents in the	K 056	K 056 IDENTIFIED RESIDENT ACTION: No residents were specifically identified, but this issue has the potential to affect all residents. CORRECTIVE ACTION: The food products stored on the top shelf were removed to prevent reduction of the 2 sprinkler heads and their coverage area. Area was marked with tape to show the correct distance. An All Staff In-service was held on 8-3-06 to discuss fire and life safety issues to include walk-in.	

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K 056	Continued From Page 5 service wing and dining room. On the date of the survey the facility was licensed for 108 beds and had a census of 97. Findings included: During the facility tour on 7/25/06 at approximately 10:30 a.m. survey staff observed 2 blocked and impeded sprinkler heads in the Walk-in Cooler and Walk-in Freezer. The blockage was from food products being stored on the top shelves of the cooler and freezer, effectively reducing the sprinkler coverage in the area. The above finding was observed and acknowledged by the Maintenance Director.	K 056	ONGOING COMPLIANCE: The Dietary Manager monitor walk-in and maintain the proper distance as marked. QUALITY ASSURANCE: The Maintenance Director will monitor for compliance. Areas of concern will be addressed as needed. Completion date: 8-29-2006	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Based upon observation and staff interview made on 07/25/06, the facility did not ensure that exit access corridors are maintained free of obstructions for the full required width of the corridor. This practice had the potential to affect all residents and staff. The facility is licensed for 108 residents and had a census of 97 at the time of the survey. Findings included: 1. Two of four resident care corridors in the facility were observed by survey team and maintenance staff	K 072	K 072 INDENTIFIED RESIDENT ACTION: No residents were specifically identified, but this issue has the potential to affect all residents. CORRECTIVE ACTION: 1-The facility conducted an all staff in-service on 8-3-06 to discuss storage of med carts, when not in use, out of the corridors to remain free from obstructions. 2- The in-service also addressed the kitchen cart storage in the service wing exit corridor and proper storage to maintain the exit corridor free from obstructions. 3- The activities material (puppet stage) was permanently removed from the facility.	

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K 072	Continued From Page 6 to have med carts stored against the corridor walls. Staff interviews on 7/25/06 at approximately 10:08 a.m. confirmed the storage of these items in corridors. 2. Kitchen carts were observed by survey staff and the maintenance director to be stored in the service wing exit corridor. 3. Activities materials (puppet stage) were observed by survey staff and the maintenance director to be stored in the exit corridor near the activities room.	K 072	ONGOING COMPLIANCE: The facility Maintenance Department will continue to monitor any areas of concern and add checks for these on their facility audit tools. QUALITY ASSURANCE: The Maintenance Director will monitor for compliance. Areas of concern will be addressed as needed Completion date: 8-29-2006	
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This Standard is not met as evidenced by: Based upon observation and staff interview, the facility failed to maintain the proper flame retardant	K 074	K 074 INDENTIFIED RESIDENT ACTION: No residents were specifically identified, but this issue has the potential to affect all residents. CORRECTIVE ACTION: The curtains in the Salon and valances in the resident rooms were treated with fire retardant chemical. ONGOING COMPLIANCE: The facility Maintenance Department will maintain MSDS and follow manufacturers recommendation on periodic treatments if necessary	

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K 074	Continued From Page 7 properties for curtains and valances used as window decoration and covering. On the day of the survey the facility was licensed for 108 beds and had a census of 97 all were effected. Findings include: During the facility tour on 7/25/06 at approximately 11:02 a.m. the survey team observed decorative curtains in the Salon. The curtains were not tagged with the appropriate fire resistance tags or approvals. Interviews on 7/25/06 at approximately 9:45 a.m. with the Maintenance Director indicated no records or documentation of the curtains having been treated with flame retardant existed. Valances found in resident rooms throughout the facility had no tags, nor associated records of application of fire resistive materials as well. The Maintenance Director acknowledged a lack of tags or documentation for curtains and valances.	K 074	QUALITY ASSURANCE: The Maintenance Director will monitor for compliance. Areas of concern will be addressed as needed. Completion date: 8-29-2006	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based upon observations and staff interview the facility failed to ensure the proper functioning of natural gas fired cooking equipment as designed, in accordance with: NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Findings include: During a tour of the facility on 7/25/06 at	K 130	K 130 INDENTIFIED RESIDENT ACTION: No residents were specifically identified, but this issue has the potential to affect all residents. CORRECTIVE ACTION: The "strike anywhere" matches were removed from the shelf above the gas stove. The stove pilot light was repaired on 7-28-06 to restore proper functioning of the stove.	

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K 130	Continued From Page 8 approximately 10:40 a.m. a box of "strike anywhere" kitchen matches was observed on a shelf above the gas fired stove in the kitchen. Interview with dietary and maintenance staff at 10:40 a.m. on 7/25/06, revelaed that the stove's pilot light was not functioning properly and that the matches were necessary to light the appliance. This finding was acknowledged by the Maintenance Director. NFPA 96 Section 4.1.1 Cooking equipment used in processes producing smoke or grease-laden vapors shall be equipped with an exhaust system that complies with all the equipment and performance requirements of this standard. NFPA 96 Section 4.1.2 All such equipment and its performance shall be maintained in accordance with the requirements of this standard during all periods of operation of the cooking equipment.	K 130	ONGOING COMPLIANCE: The Dietary Department will notify immediately the failure of pilot lights operation in order to call for repair. QUALITY ASSURANCE: The Maintenance Director will monitor for compliance. Areas of concern will be addressed as needed. Completion date: 8-29-2006	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation it was determined that the facility failed to ensure compliance with electrical safety regulations. The facility had 108 beds and a census of 97 all residents and staff were affected. Findings include: 1. During a tour of the facility on 7/25/06 at approximately 9:27 a.m. an electrical extension cord was observed by the survey team providing power to a vending machine in an outside employee break area near the emergency generator.	K 147	K 147 INDENTIFIED RESIDENT ACTION: No residents were specifically identified, but this issue has the potential to affect all residents. CORRECTIVE ACTION: 1-The electrical extension cord to the vending machine in the outside break area was removed from the machine. 2- The Juke Box was moved so that the extension cord running behind the fish tank was no longer needed to provide	

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IDAHO FALLS HEALTH & REHABILITATION	3111 CHANNING WAY IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 147	Continued From Page 9 2. During the facility tour at approximately 9:40 a.m. an electrical extension cord was observed by the survey team providing power to to a Juke Box in the TV room, the extension cord was run behind a fish tank. 3. During the facility tour at approximately 10:00 a.m. an unlisted power strip was observed by the survey team powering computer and office equipment in the Medical Records room. Each of the above findings were witnessed by the Maintenace Director.	K 147	power. 3- The unlisted power strip in the Medical Records room for the computer and office equipment was replaced with an approved power strip with circuit breaker built in. ONGOING COMPLIANCE: The facility Maintenance Department will continue to monitor on a monthly basis as a safety committee walk-thru. QUALITY ASSURANCE: The Maintenance Director will monitor for compliance. Areas of concern will be addressed as needed. Completion date: 8-29-2006	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135107	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	07/25/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS HEALTH & REHABILITATION	3111 CHANNING WAY IDAHO FALLS, ID 83404

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. Type of structure: The facility is a single story, type V (111) construction with a composite pitched roof and multiple exits to grade with four residential wings, a service wing, and a central core. The facility was originally constructed/completed on November 30,1988 . It is fully sprinklered with fire alarm and detection devices. Currently the facility is licensed for 108 beds and had a census of 97. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on 7/25/06. The facility was surveyed under IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The surveyors conducting the survey were: Debra Ransom, RN, RHIT Bureau Chief Facility Standards Mark Grimes, Supervisor Facility Fire Safety & Construction Taylor Barkley Health Facility Surveyor	C 000	RECEIVED AUG 2 2 2006 FACILITY STANDARDS	
C 230	02.106,02,b b. Existing facilities licensed prior to the effective date of these rules, regulations and minimum standards and in compliance with a previous edition of the Life Safety	C 230		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

HCA. 8/21/06

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 230	Continued From Page 1 Code may continue to comply with the edition in force at that time. This Rule is not met as evidenced by: * Refer to K018 as it relates to smoke compartment doors; Refer to K025 as it relates to smoke barrier penetrations, Refer to K029 as it relates to hazardous area smoke barrier penetrations, Refer to K056 as it relates to blocked sprinkler heads, Refer to K072 as it relates to obstructed corridors, Refer to K074 as it relates to flammability of decorative curtains, Refer to K130 as it relates to failure to maintain gas fueled equipment, Refer to K147 as it relates to extension cords and multiple power strip usage on the CMS - 2567.	C 230	SEE POC	